STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963950	**03/14/2018**
NAME OF PROVIDER OR SUPPLIER **BENEVA LAKES ASSISTED LIVING CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **743 S. BENEVA ROAD SARASOTA, FL 34232**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced complaint survey for CCR #2018003682 was conducted on . . . . at Beneva Lakes Assisted Living Center, an assisted living facility (license #6563) in Sarasota, Florida.

The following deficiencies were found at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and staff and resident interview, the facility failed to ensure that 1 (Resident #1) of 3 residents were treated with consideration, respect, and personal dignity relating to a reasonable request for caregiver assignment of resident care on the evening shift.

The findings included:

On at 9:10 a.m., upon entrance into the facility, the Executive Director (ED) and Assistant Executive Director ( ) were asked if any resident(s) in the facility refused care from any caregiver. The stated, "No, that was resolved."

Record review showed Resident #1 filed a grievance on . It stated "she was getting a sandwhich [sandwich] from the med tech station and he [Caregiver Staff C] questioned why she was in there alone retreving [retrieving] a sandwhich. Resident does not feel adequate customer service and empathy were carried out. ED and spoke to staff member on how to appropriately handle resident's disrespectful behavior towards staff member. follow up with resident, resident okay with one to one counseling with med tech as it relates to customer service."

Review of the medical record revealed that Resident #1 has not been in the facility since . . . . . She is staying with a family member.

On at 11:25 a.m. the foregoing grievance on record at the facility dated was read to Resident #1. Resident #1 said she did not complete the grievance, never saw it, and the resolution was not discussed with her. She also said that she told the facility that she did not want the staff member (Caregiver/Staff B) involved in the grievance, to enter her , or provide her any assistance. She was told "that could not be done." She then stated, "I thought I had the right to request that."

During separate interviews on , both Caregiver/Staff A at 1:45 p.m., and Caregiver/Staff C at 3:50 p.m., stated they had no difficulties providing assistance to Resident #1, they found her pleasant and

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, . They also said they were unaware of any caregiver not being able to provide her with care.

During an interview on at 2:20 p.m., Caregiver/Staff B revealed he had no difficulties providing Resident #1 with assistance with self-administration of medications. He continued to state he did have difficulty with her getting snacks. He stated, "she got in my face and I stepped back. This happened on and I reported it [to the] the same night [called her], and had a meeting with her the next day. I was told to ignore her [the resident] and don't say anything to her if she approaches me with negative/offensive comments." He said he goes in Resident #1's empty garbage and "she doesn't need any other help. I have not given her medications since that time, she has not been here." He also stated (when asked) that he did not sign anything indicating that he was inserviced or re-educated regarding /mistreatment or resident rights.

During an exit interview on at 4:15 p.m., the ED and presented an "Education In-Service Attendance Record" for Caregiver/Staff B, dated (readdressed) with the topic "Customer Service".

On at 4:15 p.m., the stated she was unaware of any documentation, written by Resident #1, relating to the incident on . She also acknowledged that the Grievance Form, of , did not include any written acknowledgement that Resident #1 was provided with the opportunity to read the form to indicate agreement with the resolution and followup.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on record review and staff and resident interview, the facility failed to follow physician orders to provide administration of medications for 1 (Resident #1) of 1 resident reviewed for physician orders.

The findings included:

Record review on , of Resident #1's medical record revealed an ACHA Form 1823, dated and signed by the physician on , , 2017, that stated the resident "Needs Medication Administration. Not all ALFs have licensed staff to provide this service." Further review of the record revealed no clarification or change of this order.

During an interview on at 1:45 p.m., Caregiver Staff A stated he provides assistance to Resident #1 for self-administration of medications. In addition, an interview with Caregiver Staff B at 2:20 p.m.

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and Caregiver/Staff C at 3:50 p.m. revealed that they provide assistance to Resident #1 for self-administration of medications.

During an interview on at 4:15 p.m., the Executive Director and Assistant Executive Director acknowledged that the order for medication administration was not implemented and needed to be clarified by the physician.

Class III